October 27, 2004

MDR Tracking #: M2-05-0095-01
IRO Certificate #: 5284

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Medical Doctor who is board certified in General Surgery. The reviewer is on the TWCC ADL. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 57-year-old man who sustained a left shoulder injury in ___. He underwent a partial acromioplasty and a question of a rotator cuff repair in May of 2000. He has complained of persistent pain, weakness and decreased range of motion in that arm. He underwent an arthrogram in September 2003 which was read as normal. An EMG done in November 2003 showed bilateral acute C7 radiculopathy. In January of 2004 it was recommended that he have a C6-C7 discectomy with fusion but I have no records of that procedure being performed. He has used the RS-4i stimulator from 10/16/03 through at least 8/31/04. There is no mention in the physician's office notes of this device being effective.

REQUESTED SERVICE

The requested service is the prospective purchase of an RS-4i Sequential Stimulator 4 channel combination Interferential and Muscle Stimulator Unit.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer indicates that there is no published data on the efficacy of this device, or devices of this type, for treatment and rehabilitation of shoulder pain. As such, this has to be considered unproven and/or experimental treatment. (Managing musculoskeletal complaints with rehabilitation therapy; summary of the Philadelphia Panel evidence based clinical practice guidelines on musculoskeletal rehabilitation interventions. Harris GR, Susman JL. J Fam Pract. 2002 Dec;51 (12):1042-6.)

The reviewer further indicates that published data with regard to back pain utilizing similar modalities, such as spinal cord stimulation, fail to show any significant benefit from long term use of these devices. There is only modest clinical improvement when this modality is used in conjunction with physical therapy as compared with physical therapy alone, which diminishes over 6-12 months (Spinal cord stimulation for patients with failed back surgery syndrome or complex regional pain syndrome: a systematic review of effectiveness and complications. Turner JA, et al Pain. 2004 Mar; 108 (1-2):137-47. Spinal cord stimulation for complex regional pain syndrome: an evidence based medicine review of the literature. Grabow TS, et al Clin J Pain. 2003 Nov-Dec; 19(6):371-83).

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy. ___ believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 17787, Austin, TX 78744. The fax number is 512-804-4011. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(u)(2).

Sincerely,

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 28th day of October 2004.